Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DBA INJURY 1-DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Carrier's Austin Representative Box
Box Number 15

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Date Received
March 3, 2011

MFDR Tracking Number
M4-11-2222-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The service was provided and the claims were denied per EOB based on the findings of the review organization. CPT code 97799 CPCA was preauthorized therefore it was deemed medically necessary. The claims came back denied based on extent of injury. The treatment that was provided is part of his compensable injury to his low back that he sustained on 08/18/08. Extent of injury issues has been resolved per CCH D&O. In summary, it is our position that Gallagher Bassett has established an unfair and unreasonable time frame in paying for the services that were medically necessary…"

Amount in Dispute: $4,798.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated March 14, 2011: "We have escalated the bill for additional review and it remains in process at this time. We will submit a supplemental response upon completion of the pending review."

Response Submitted by: Gallagher Bassett Services, Inc., 6504 International Parkway, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 7, 2010	97750-GP x 4 units	$173.36	$173.36
October 21, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (7.5 hours)	$937.50	$937.50
October 22, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (7.5 hours)	$937.50	$937.50
October 26, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (8 hours)	$1,000.00	$1,000.00
October 27, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (8 hours)	$1,000.00	$1,000.00
October 29, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (6 hours)	$750.00	$750.00
November 3, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (6.75 hours)	$0.00	$0.00

November 4, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (6.75 hours)	$0.00	$0.00
November 5, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (6.5 hours)	$0.00	$0.00
TOTAL		$4,798.36	$4,798.36

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

The Division received notice from requestor's representative, Judith Guerra, via email, on October 2, 2012 indicating the carrier has paid disputed dates of service, November 3, 2010, November 4, 2010 and November 5, 2010, however September 7, 2010, October 21, 2010, October 22, 2010, October 26, 2010, October 27, 2010 and October 29, 2010 remain unpaid and in dispute.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. 28 Texas Administrative Code §134.204 sets out medical fee guidelines for workers' compensation specific services provided on or after March 1, 2008.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 5, 2010
   - 216 – BASED ON PEER REVIEW AND EXTENT OF INJURY

   Explanation of benefits dated November 5, 2010
   - 219 – Based on extent of injury.

   Explanation of benefits dated November 6, 2010
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer
   - 216 – Based on the findings of the review organization.

   Explanation of benefits dated November 12, 2010
   - 219 – Based on extent of injury.

   Explanation of benefits dated November 16, 2010
   - 19 – (197) – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - BL – TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC

   Explanation of benefits dated November 17, 2010
   - 19 – (197) – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - BL – TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC

   Explanation of benefits dated December 4, 2010
   - 219 – Based on extent of injury.

   Explanation of benefits dated December 10, 2010
   - 19 – (197) – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - BL – TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC
   - 219 – Based on extent of injury.

   Explanation of benefits dated December 18, 2010
   - 216 – Based on the findings of the review organization.
   - 219 – Based on extent of injury.

Explanation of benefits dated December 24, 2010
- 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer
- 219 – Based on extent of injury.

Explanation of benefits dated January 14, 2011
- 219 – Based on extent of injury.

Explanation of benefits dated January 22, 2011
- 219 – Based on extent of injury.

Issues

1. The carrier has addressed the issue of compensability/extent of injury for the claim. Has the compensability/extent of injury issue been adjudicated?
2. Is the requestor entitled to reimbursement for CPT Code 97750-GP?
3. Did the requestor obtain preauthorization approval prior to providing the chronic pain management program in dispute in accordance with 28 Texas Administrative Code §134.600?
4. Is the requestor entitled to reimbursement for CPT Code 97799-CP-CA?

Findings

1. The PLN-11, Notice of Disputed Issue(s) and Refusal to Pay Benefits filed by the insurance carrier on June 10, 2010 states in pertinent part, "The carrier accepts the compensable injuries as cervical and lumbar strains and chest and abdominal contusions only. The carrier disputes any other diagnosis or extent of injury as it related to the accepted compensable injury, these injuries were also documented in the CCH decision of 9/14/10." The provider billed the disputed treatment for the diagnosis, 847.2 (lumbar sprain/strain). The Division has determined that the extent of injury issue has been resolved, therefore the disputed services will be reviewed per the applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code, Section §134.203(c)(1) the calculations for CPT code 97750 x 4 Units is as follows:

   CPT Code 97750 x 4 Units: $54.32 WC CF/36.8729 Medicare CF x $30.48 Participating Amount = $44.90 x 4 Units = $179.60.

   The total MAR for CPT code 97750 x 4 Units billed on September 7, 2010 is $183.56. According to the Table of Disputed Services, the requestor is seeking $173.36, therefore, this amount is recommended.
3. 28 Texas Administrative Code §134.600(p)(10) requires preauthorization of "chronic pain management/interdisciplinary pain rehabilitation." Review of the submitted preauthorization letter dated October 19, 2010 supports the Chronic Pain Management Program x 10 sessions was approved under authorization number 9003637 with a start date of October 18, 2010 and an end date of November 30, 2010 which includes the disputed services. The requestor has supported their position that the disputed chronic pain management program was preauthorized per 28 Texas Administrative Code, Section §134.600; therefore, the requestor is entitled to reimbursement as follows per 28 Texas Administrative Code, Section §134.204.
4. Per 28 Texas Administrative Code §134.204(h)(5)(B), states "Reimbursement shall be $125.00 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes." A CARF accredited program is indicated by using the modifier –CA. Review of the submitted documentation finds that based on the factual determination that the provider did bill the disputed services with the –CA modifier, therefore, the monetary value of the program will be 100% of the CARF accredited value.

   DOS October 21, 2010: $125.00 x 7.5 hours = $937.50

   DOS October 22, 2010: $125.00 x 7.5 hours = $937.50

   DOS October 26, 2010: $125.00 x 8 hours = $1,000.00

   DOS October 27, 2010: $125.00 x 8 hours = $1,000.00

   DOS October 29, 2010: $125.00 x 6 hours = $750.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $4,798.36.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,798.36 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 3, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.